care facility, or other medical institution if the individual is required (pursuant to § 435.725, § 435,733, § 435.832, or § 436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) *Emergency services.* Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in—

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(5) *Family planning.* Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.

(c) *Prohibition against multiple charges.* For any service, the plan may not impose more than one type of charge referred to in paragraph (a) of this section.

(d) *State plan specifications.* For each charge imposed under this section, the plan must specify—

(1) The service for which the charge is made;

(2) The amount of the charge;

(3) The basis for determining the charge;

(4) The basis for determining whether an individual is unable to pay the charge and the means by which such an individual will be identified to providers; and

(5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

(e) No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing.

[43 FR 45253, Sept. 29, 1978, as amended at 47 FR 21051, May 17, 1982; 48 FR 5736, Jan. 8, 1983; 50 FR 23013, May 30, 1985; 55 FR 48611, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 67 FR 41116, June 14, 2002]

§ 447.54 Maximum allowable charges.

(a) *Non-institutional services.* Except as specified in paragraph (b), for non-institutional services, the plan must provide that—

(1) Any deductible it imposes does not exceed $2.00 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for that period of eligibility is $6.00;

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and

(3) Any co-payments it imposes do not exceed the amounts shown in the following table:

States payment for the service	Maximum copayment chargeable to recipient
$10 or less	$.50
$10.01 to $25	1.00
$25.01 to $50	2.00
$50.01 or more	3.00

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it

imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983]

EFFECTIVE DATE NOTE: At 73 FR 71851, Nov. 25, 2008, § 447.54 was amended by revising the section heading, (a) introductory text, (1) and (3), adding a new introductory text and (a)(4), effective March 27, 2009. At 74 FR 4888, March 27, 2009, the effective date was delayed until Dec. 31, 2009. For the convenience of the user, the added and revised text is set forth as follows:

§ 447.54 Maximum allowable and nominal charges.

Except as provided at §§ 447.62 through 447.82 of this part, the following requirements must be met:

(a) *Non-institutional services.* Except as specified in paragraph (b) of this section, for non-institutional services, the plan must provide that the following requirements are met:

(1) For Federal FY 2009, any deductible it imposes does not exceed $2.30 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family is $6.90. Thereafter, any deductible should not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher 5-cent increment.

* * * * *

(3)(i) For Federal FY 2009, any co-payments it imposes under a fee-for-service delivery system do not exceed the amounts shown in the following table:

State payment for the service	Maximum copayment
$10 or less	$0.60
$10.01 to $25	1.15
$25.01 to $50	2.30
$50.01 or more	3.40

(ii) Thereafter, any copayments should not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(4) For Federal FY 2009, any copayment for services provided by an MCO may not exceed the copayment permitted under paragraph (a)(3)(i) of this section for comparable services under a fee-for-service delivery system, except as provided in this paragraph. When there is no fee-for-service delivery system, the copayment may not exceed $3.40 per visit or for individuals referenced in an approved State child health plan under title XXI pursuant to § 457.70(c), $5.70 per visit. In succeeding years, any copayment should not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

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§ 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum co-payment amounts specified in § 447.55 (a) and (b) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is $4 to $5 per prescription, the agency might set a standard copayment of $0.50 per prescription.

EFFECTIVE DATE NOTE: At 73 FR 71851, Nov. 25, 2008, § 447.55 was amended by revising paragraph (b), effective March 27, 2009. At 74 FR 4888, March 27, 2009, the effective date was delayed until Dec. 31, 2009. For the convenience of the user, the revised text is set forth as follows:

§ 447.55 Standard co-payment.

* * * * *

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54(a) and (b) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is $4 to $5 per prescription, the agency might set a standard copayment of $.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under § 447.54(a)(3).

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§ 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-related deductible, coinsurance or copayment charges. For example, an agency may impose a higher charge on